

State of Michigan
Department of Civil Service
EMPLOYEE BENEFITS DIVISION
Flexible Spending Accounts
Capitol Commons Center, 4th Floor
400 South Pine Street, P.O. Box 30002
Lansing, Michigan 48909

☐ Health Care
☐ Dependent Care

FLEXIBLE SPENDING ACCOUNTS

LIFE EVENT/ELECTION CHANGE FORM			
Instructions: Complete this form to report a change in status in either the Health Care or Dependent Care Flexible Spending Account for the current calendar year. Documentation must be provided within 30 days of the qualifying life event in order for the change to be processed. Sign and date the form, attach supporting documentation, retain a copy of the form and the supporting documentation for your records, and send to the address above. A portion of this information is protected by federal privacy laws and/or state confidentiality requirements. Do not use this form for enrollment. Use the CS-1773 Health Care Flexible Spending Account Midyear Enrollment form or the CS-1774 Dependent Care Flexible Spending Account Midyear Enrollment form.			
PLEASE PRINT OR TYPE			
Name		Daytime Phone Ext.	
Home Address		Employee ID Number	
City		State	Zip Code
Current Biweekly Deduction \$	New Biweekly Deduction \$	Number of Pay Periods For Deduction (1 to 26)	
Life Event (Check one below):	Date of Event	Documentation Needed: (Please send copies)	
<input type="checkbox"/> 1. Birth of Child		Birth Certificate	
<input type="checkbox"/> 2. Adoption of Child		Legal Documentation	
<input type="checkbox"/> 3. Death of Dependent		Death Certificate	
<input type="checkbox"/> 4. Gain Custody of Dependent		Legal Documentation	
<input type="checkbox"/> 5. Lose Custody of Dependent		Legal Documentation	
<input type="checkbox"/> 6. Addition of Incapacitated Adult or Child to Household		Documentation to Certify Incapacitation	
<input type="checkbox"/> 7. Legal Separation		Legal Documentation	
<input type="checkbox"/> 8. Divorce		Divorce Decree	
<input type="checkbox"/> 9. Marriage		Marriage License	
<input type="checkbox"/> 10. Death of Spouse		Death Certificate	
<input type="checkbox"/> 11. Change in Employment Status		Documentation from Employer	
<input type="checkbox"/> 12. Other, Specify: _____		Specified by Employee Benefits Division	
<p><i>I authorize the State of Michigan to reduce my gross biweekly salary in the amount specified above in the New Biweekly Deduction box.</i></p> <p><i>I understand that according to Federal Regulation, any money remaining in my account at the end of the year and its corresponding grace period must be forfeited.</i></p> <p><i>I certify that the information provided on this form is true and complete. I understand that any misstatement or falsification of material facts will result in my removal from the Spending Account, and may cause an IRS and/or state audit with possible additional tax, interest, and penalties due.</i></p>			
Employee's Signature			Date